Supreme Court, U.S.
FILED

93 1509 JAN 21 1994

OFFICE OF THE CLERK

APPLICATION NUMBER A-474

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1993

THOMAS B. KEE, PETITIONER

vs.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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75 pp

QUESTIONS PRESENTED FOR REVIEW AND BASIS FOR WRIT OF CERTIORARI

I. Whether a person's state of mind in responding to questions on an insurance policy application is critical to determining the issue of misrepresentation as it relates to the insurer's ability to rescind the policy within the contestability period?

II. Is a state statute which deals with the application of the incontestability clause to an insurance policy unconstitutionally vague on its face when it contains language critical to the determination of the expiration of the incontestability

period which is contradictory and confusing and a violation of the 14th Amendment to the United States Constitution?

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Supreme Court Rule 14(.1)(d)

OFFICIAL AND UNOFFICIAL REPORTS OF OPINIONS

For official and unofficial reports of opinions delivered in the case by other courts:

Please see Appendeix for previous opinions on this case and the table of authorities (citations of case law) on which Petitioner relies.

Supreme Court Rule 14(.1)(e)

GROUNDS ON WHICH THE JURISDICTION OF THIS COURT IS INVOKED

Supreme Court Rule 14(.1)(e) response:

(i) The date of entry of the judgement sought to be reviewed:

April 27th, 1992.

(ii) The date of the order respecting a rehearing:

September 3rd, 1992.

The date and terms of the order granting an extention of time within which to file the petition for a writ of certiorari:

Entered December 15th,

1992.

Granted to January 21st, 1993.

(iv) The statutory provision believed to confer on this Court jurisdiction to review the judgement or decree in question by writ of certiorari:

This Petition is based upon Supreme Court Rules 10(.1)(a) and (c).

Supreme Court Rule 14(.1)(f)

CONSTITUTIONAL PROVISIONS AND STATUTES

The Fourteenth Amendment to the U.S. Constitution.

Florida Statute 627.607.

Florida Statute 627.409.

Please see Appendix for verbiage of the above inasmuch as they are too lengthy to present here.

Supreme Court Rule 14(.1)(g)

Please see the narritive - herewith - pages 1-19.

Supreme Court Rule 14(.1)(i)

In re statement of the case the basis invoked by Plaintiff for Federal Jurisdiction is Diversity.

Supreme Court Rule 14(.1)(j)

Please see the narritive - herewith - pages 20-45.

CONCISE STATEMENT OF THE CASE

On February 4th, 1986, the Petitioner, Thomas B. Kee applied for a disability insurance policy with the Respondent Provident Life Insurance Company. The application was approved and bore an issue date of April 25, 1986 and an effective date of May 5, 1986.

In filing its action to rescind Kee's policy, Provident contended that Kee had made certain material misrepresentations in completing his application. Although asserting that Provident's rescission claim was barred by the two-year contestability limitation contained in the policy, Kee never conceded that he had made

any material misrepresentations in the application, contrary to the allegations made by Provident (Exhibit "A" - Trial Court Pleadings and Provident's Answer Brief).

In fact, this is only one of the several remarkable examples of the way Provident has cleverly cited the record on appeal in order to create "facts" which never existed. Kee has consistently denied having ever made any material misrepresentations in his application and stands by that assertion to this day.

Kee truthfully answered all the questions to the best of his knowledge since the pertinent questions asked if he had ever been <u>treated</u> for any of the illnesses. At the time that Kee was seeing his psychiatrist, Dr.

Arthur Stillman, he was not advised by the doctor or anyone else that he was suffering from bi-polar affective disorder or any other illness, mental or otherwise (Exhibit "B").

Therefore, Kee continues to stand by his original statement that he was answering these questions truthfully and still contends that he was not suffering from any illness that had manifested itself at that time. In Kee's case, even though the illness had been diagnosed by Dr. Stillman, it had not manifested itself in any way whatsoever nor had it affected Kee's behavior or obvious ability to earn a living.

It should be noted that in completing the application, Kee received the assistance of Provident's general

agent at the time, Michael Eskra. Not only did Eskra make suggestions but he also completed portions of the application in order to expedite the issuance of the policy.

On May 4, 1986, one day prior to the expiration of the incontestability period (using the effective date as controlling), Provident filed an action in the Southern District of Florida to rescind the policy. The date of the Provident action cannot go unnoticed since Kee had not filed a claim under the policy and had not even suggested that he would at the time the action for rescission took place.

When viewed in the context of the Florida statute involved, it becomes apparent that Provident may

have outwitted itself in its attempt to file its action at the last possible moment. It will be shown that the statute in question as well as many others affecting the insurance industry were drafted by the legislature while under considerable pressure from the insurance industry.

A detailed examination of the history of the incontestability provisions as they apply to insurance contracts reveals that they were designed to cure the evils which had become rampant throughout the insurance industry. Before the enactment of legislation in the form of mandatory incontestability clauses in insurance policies, it had become standard practice within the insurance industry to underwrite policies at the time

a claim was filed.

In other words, insurance companies were waiting until claims were filed in order to begin their search for possible misrepresentations in the original application. This procedure left the policy holder virtually helpless since he was at the mercy of unscrupulous insurance companies which could deny coverage for practically any reason after having collected premiums for many years.

This intolerable process was compounded even further in Petitioner's case in that this type of unethical conduct was initiated before Kee filed a claim or even suggested that one would be filed. After all, anyone intent on deceiving an insurance company by misrepresenting

his medical history would never alert them in advance by filing a claim prior to the expiration of the incontestability period but rather would "wait out" the appropriate period in the hope that his designs were not uncovered (Exhibit "C").

Assuming arguendo that Provident was within its rights in launching its last-minute and perfuntory investigation, it still fits the pattern of abuse which characterized the behavior of the insurance industry back in the days in which it was allowed to operate virtually unrestrained by any governmental controls.

Despite repeated attempts by the various legislatures to correct this problem, the abuses still continue and, in some cases, have become even

more obvious. A litany of reasons can be cited for the continuing nature of these problems but primary among them is the lack of uniformity from state to state and the hopelessly vague and confusing interchangeability in the use of contradictory terminology in the drafting of state statutes which ostensibly were designed to cure the problem.

The Florida Statute on the incontestability of an insurance policy is a case in point. Florida Statute section 627.607 (1982) reads as follows:

> The contract shall include the following provision:
>
> (1) Time Limit on certain defenses: After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss

incurred or disability starting after the 2-year period.

(2) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least 5 years from its date of issue may, in lieu of the provision set forth in subsection (1) include the following provision:

Incontestable:

(a) Misstatements in the Application: After this policy has been in force for 2 years during the insured's lifetime (excluding any period during which the insured is disabled), the insurer cannot contest the statements in the application.

(b) Preexisting Conditions: No claim for loss incurred or disability starting after 2 years from the issue date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before

> the effective date of coverage. (emphasis added).

Even a cursory examination of the statute reveals the confusion which could easily result from the continuous use and interplay among the various terms used to determine the triggering dates for measuring the contestability period.

When one considers the fact that even the courts have agonized over the meaning of these terms and their applicability to insurance contracts, it becomes readily apparent that the average policy holder could not be expected to decifer the subtle differences which accompany the use of these phrases and the effect they could have upon their rights under the policy.

The statute gives the insurer the option of substituting for one or more of the provisions, corresponding provisions of different wording approved by the Department of Insurance which are, in each instance, not less favorable in any respect to the insured. (30 Fla. Jur. 2d Sec. 371).

Provident has chosen to reword the incontestability clause of its policy which endeavors to make the policy, as a whole, less favorable to the insured by substituting the words "effective date" in place of "issue date".

The Florida courts apparently have never made a determination of the precise meaning of the term "in force" as it applies to a policy of disability insurance. However, other

jurisdictions have had been called upon to clarify statutes which contain similar language and have reached varying conclusions.

In GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, INC. v. SCHAEFER, 519 N.E. 2d 288 (NY 1987), 524 N.Y.S. 2d 377 (Ct App. 1987), the New York Court of Appeals held that the two-year incontestability period began to run from the date of the disability policy's issuance, rather than the the policy's effective date, in that the term "in force", as used in the incontestability clause was ambiguous and would be construed against the drafter of the policy.

The Court in SCHAEFER stated: "Resolution of this dispute depends on whether the term "in force", as

used in the incontestability clause, means the "date of issue" or the "effective date" of the policy. Nowhere does the policy itself or the applicable statute governing incontestability clauses in accident and health policies define the term "in force". That phrase arguably could apply to either the date of issue or the effective date. Thus, the term "in force" is ambiguous and the rule of construction that ambiguities in contracts must be construed against the drafter is applicable". SCHAEFER at p. 378.

The New York Statute, upon which the Court's decision was based, contains language almost identical to the Florida Statute as it relates to the substitution of provisions utilizing different wording than what

is mandated by the statute itself and requiring that the substituted provision not be less favorable in any respect to the insured.

The determination of the date when the policy becomes effective has been a troublesome one to the courts for many years. The courts have been faced with the problem on the one hand of enforcing a contract as made, and on the other of giving a liberal construction to such contracts, recognizing that such contracts are drafted wholly by one party thereto, and that the other is inexperienced in such matters and usually unaware of the legal effect of such instrument.

Because of these various matters of public policy confronting the courts, there are no uniform rules

laid down which absolutely govern the time when the contract is considered to go into effect. However, the courts have made an effort to adopt dates as controlling that would allow them to find that the contestable period had run.

Of critical importance in analyzing the applicability of the incontestability clause to Kee's policy is the fact that the policy at issue in the instant case was, in effect, a continuation of several non-cancellable policies which Kee had owned for some 23 years prior to their unexplained lapse and cancellation by Provident in 1985. Provident's own general agent exercised a great deal of influence over Kee in convincing him to purchase a new policy instead

of reinstating the old ones.

It should be noted that the Petitioner tendered a payment of $400 and signed for the Provident general agent an INSURmatic bank draft form (which Provident takes in lieu of a binding check) at the time of the application for the purpose of binding the new policy since he was about to embark on an around-the-world trip shortly thereafter. He was assured by Provident's general agent that the payment would be sufficient at the time and he would be advised when the next payment would be due.

Additionally, Kee could easily have bound the policy himself and retained the estimated premium since he could act as the agent for his own policy and thereby forego the necessity

of collecting any money at all. (Exhibit "D"). The agent would be due his commissions for generating the business thereby reducing the amount of premium payment needed to bind the policy. In this context, Kee's tendering of $400 was more than sufficient to meet this requirement.

Kee had a right to feel that he was covered under the terms of the policy since the average applicant who has paid his premium and successfully passed his physical examination would not by the remotest chance understand that he was not covered until the insurer at his leisure approved the risk; he would assume that he was getting immediate coverage for his money.

The need for a higher premium

would never have become an issue had Provident's own general agent, Eskra, not sought higher coverage. In fact, it was at Eskra's suggestion that Kee opted for increased coverage while assuming at the time that the previously-quoted premium was applicable to the higher coverage. (Kee had no access to nor understanding of Eskra-Provident's premium computers in their offices which were seperate from his own and therefore had to rely on Provident's employees for advice.) Additionally, Kee had long before opted to have his premium payments deducted from his commission check while working for another insurance company through what is known as the Employee Deduction/INSUREmatic account.

Nevertheless, had Provident

determined that the check tendered by Kee with his application was an inadequate amount to cover the policy, they should have informed him within 10 days so that any shortage could be resolved.

PROCEEDINGS IN LOWER COURT

On May 4, 1988, Provident filed an action to rescind Kee's disability insurance policy on the basis that Kee's application contained material misrepresentations. While focusing on the 2-year contestability period as a bar to Provident's action to rescind the policy, Kee made no concessions regarding the issue of material misrepresentations, contrary to Provident's assertions (Exhibit "A", supra).

On June 15, 1990, the district court entered summary judgment in favor of Provident (Exhibit "E"). In so ruling, the district court found that Provident had filed its action for

rescission prior to the expiration of the policy's 2-year contestability period.

Summary judgment was granted by the district court despite the fact that there were several genuine issues of material fact which remained to be resolved. These included, but were not limited to, the materiality of the alleged misrepresentations, Kee's state of mind at the time the application was completed and the amount of premium necessary to bind the policy.

On August 23, 1990, Kee filed his Notice of Appeal with the Eleventh Circuit Court of Appeals. On April 27, 1992, the Eleventh Circuit Court of Appeals affirmed the judgment of the district court stating that the action was filed within the two-year

period allowed to contest statements made in the application. Additionally, the Court held that there was no dispute concerning misrepresentations in the relevant medical history and that the policy would not have issued but for those omissions.

As the result of these adverse rulings and certain constitutional issues raised thereby, Kee has filed the instant Petition for Writ of Certiorari with this Court.

ARGUMENT

Provident's action to rescind Kee's policy of non-cancellable and guaranteed renewable disability insurance was predicated on the allegation that certain misrepresentations had been made in the application for insurance and that these alleged misrepresentations allowed for rescission by Provident under Florida Statute 627.409(1)(1987). Provident successfully argued in the lower court that the applicant's state of mind made no difference and that even an innocent misrepresentation was grounds for rescission of the policy if it were material to the acceptance of the risk.

In completing the application, Kee was asked if,"within the past five years he had had any mental or physical disorder", to which the applicant responded "no". (Question 5a of Provident's application). This answer was given truthfully to the best of Kee's knowledge since he was totally unaware of any diagnosis pertaining to the bi-polar affective disorder of which he later learned he had been suffering. The psychiatrist who examined Kee, Dr. Arthur Stillman, had never revealed to him the results of his diagnosis but instead had shared the information with Kee's attorney and no one else (Exhibit "B", supra).

The main focus of Provident's argument was the statutory language of the afore-mentioned Florida Statute

627.409(1) which reads in pertinent part that:

> "Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:
>
> a. They are fraudulent.
>
> b. They are material, either to the acceptance of the risk or the hazzard assumed by the insurer: or
>
> c. The insurer in good faith would either not have issued the policy or contract, would not have issued it at the same premium rate, would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazzard resulting in the loss if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

Kee has argued vehemently

that he had no way of knowing that he was suffering from any potentially debilitating illness at the time he filled out the application. However, Provident relied heavily upon the holding in LIFE INSURANCE COMPANY OF VIRGINIA v. SHIFFLET, Fla. 1967, 201 So2d 715, which states that even an innocent misrepresentation by the insured can bar recovery if it is material to the acceptance of the risk or if the insurer, in good faith, would not have issued the policy under the same terms had it known the truth.

In HYMAN v. LIFE INSURANCE COMPANY OF NORTH AMERICA, 481 F2d 441 (1973) the Court recognized that the SHIFFLET holding did have its exceptions and, in certain instances, could produce harsh results. In a concurring opinion,

joined by three other Justices, in NATIONAL STANDARD LIFE INSURANCE COMPANY v. PERMENTER, 204 So2d 206 (Fla. 1967), Justice Ervin suggested a case-by-case approach to avoid injustice in situations in which

> "an applicant may express an erroneous opinion concerning a specific question relating to his health, of which he has no medical knowledge, and which could only be answered by a medical expert after diagnosis and examination."

204 So2d at 207.

Provident recognizes the fact that the SHIFFLET rationale suffered a gradual erosion by subsequent appellate court decisions but was reaffirmed and revitalized by the Florida Supreme Court in CONTINENTAL

ASSURANCE CO. v. CARROL, 485 S0 2d 406 (Fla. 1986). However, in an intermediate decision by the Fourth District Court of Appeals, CONTINENTAL ASSURANCE CO. v. CARROLL, 459 So2d 443 (Fla. App. 4 Dist. 1984), the court had certified the question raised in the SHIFFLET case, i.e. the impact of a material misrepresentation to the acceptance of the risk and whether it would invalidate an insurance policy even if made in good faith, as being one of great public interest.

The constant ebb and flow that has been the trademark of the SHIFFLET rationale over the years was further manifested in the recent case of WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK v. SANDS, 912 F.2d 1359, in which the Eleventh Circuit Court

of Appeals further eroded the holding in CARROLL, and by extension, SHIFFLET, when it held that when the insurance company requests that the applicant answer the questions on the application to the best of his knowledge and belief, it was not entitled to rescission of the policy when negative responses were later proved to have been incorrect when they were made.

As the Court in SANDS stated:

> "An essential prerequisite to the application of Florida Statutes section 627.409(1) is that the insured make an inaccurate statement in his application."

If the insured had no knowledge of his illness at the time of the application, it would be impossible for him to make an incorrect

statement.

The Court in SANDS, quoting from SKINNER v. AETNA LIFE AND CASUALTY in which the interplay between an insurance statute and contract was considered, stated with regard to the inclusion of the qualifying language

> "to the best of my knowledge and belief,"

that the additional verbiage

> "..... had the effect of shifting the focus, in a determination of the truth or falsity of an applicant's statement, from an inquiry into whether the facts asserted were true to whether, on the basis of what he knew, the applicant believed them to be true. Thus (the applicant's) answer must be assessed in the light of his actual knowledge and belief."

The application for the Provident policy clearly contains the qualifying language referred to above (Exhibit "F") and, as such, falls within the SANDS holding whereby the applicant's knowledge of the facts forming the basis for his responses is controlling.

The Eleventh Circuit has arrived at the same conclusion in evaluating the effect of insurance contract language that provides an applicant with greater protection than the relevant state insurance statute. The Court, qouting from STATE FARM FIRE AND CASUALTY CO. v. OLIVER, 854 F. 2d 416 (11th Cir. 1988), dealing with an Alabama statute in all material respects identical to Florida Statute section 627.409, stated that

> "once (the insurer) has set its own standard by contract for judging misrepresentations and concealment, it cannot rely on a statute that imposes more stringent requirements on an insured."

To allow Provident to resort to the safe harbor of the statutory language provided by section 627.409(1) when it chose to include qualifying language of its own in the policy application, would provide Provident with the opportunity to contest any statement made in an application as a pretext for later rescinding the policy.

The continuing erosion of the SHIFFLET holding and the decided advantage which insurance companies enjoy over the average policy holder require that the goal of uniformity

in this area of the law be achieved once and for all. In order to ensure that the policy holder is not unfairly victimized by insurance companies which, in effect, are allowed to underwrite at the time of claim instead of application, it must be established that the insurer is bound by the terms of the contract it enters with the insured, especially in those cases where the insurer has carefully chosen the very terms and conditions which have later become a source of conflict.

As additional support for Kee's contention that he was unaware of the illness which later became the subject of dispute, reference is made to the testimony at Hearing of the late Dr. Arthur Stillman on where he was asked on January 9th, 1989 (Exhibit

"B", supra):

A. No. I didn't actively treat him. (p 21)

Q. . . . did you ever go into a full explanation of what your understanding, your evaluations were with Mr. Kee? (p 21-22)

A. No.

Q. Did you, in fact, prepare any evaluations that were sent to the attorney for Mr. Kee?

A. Yes.

Q. And did those evaluations go into your findings relating to Mr. Kee's mental health?

A. I think they went into it in fairly notable detail, yes.

Q. . . . were those reports or written evaluations that you prepared ever given to Mr. Kee? (p 22-3)

A. No. I never gave him--no.

Q. And you never

explained those evaluations to Mr. Kee?

A. No. I felt that was up to his attorney. (Emphasis added.)

pp. 21-23 of Stillman Court transcript.

There was no reason for Kee to believe that Dr. Stillman's prescriptions for lithium and tranquilizers were related to a bi-polar affective disorder. After all, Dr. Stillman himself admitted that he never officially treated Kee but merely examined him at the behest of his attorney. Kee was advised that the medication would help him sleep better and control his nerves.

This background is important in that the questions relevant to this case were preceded in the application by the phrase

"have you ever been treated"

for any of the following disorders. Given Dr. Stillman's own assessment of his examination of Kee, it can readily be seen that Kee correctly responded to the series of questions preceded by the phrase mentioned above.

It should be noted that Kee's condition was in the incipient stage at the time of his application for disability insurance and none of the symptoms had manifested themselves to such an extent that the average man would have been fully aware of them.

At the end of Provident's application appears the very qualifying language at issue in the SANDS case, i.e.

> "the foregoing statements are full, complete, and true to the best of my knowledge and belief."

Directly below this statement is the signature of the appellant, Thomas B. Kee.

In order to properly construe the applicant's responses to the questions posed, they must be read, as the insurance form itself states, in conjunction with the qualifier

> "to the best of my knowledge and belief."

Taken in that context, Kee's negative response to question 5a

> "Have you within the past 5 years had any mental or physical disorder not listed above",

was neither a misstatement nor a misrepresentation; they were entirely truthful and accurate.

By including the phrase

> "to the best of my knowledge and belief",

the parties have chosen a subjective test for the truthfulness of prior representations. What the applicant in fact believed to be true is the determining factor in judging the truth or falsity of his answer.

The court in SANDS, supra, held that the

> "knowledge and belief"

language used in an application form imposes a different requirement of accuracy than that provided in section

627.409 Florida Statutes. Had Provident intended to retain the ability to void the contract based on any inaccuracy, it should not have used the

"knowledge and belief"

qualifying language. Such language would reasonably induce an insurance applicant to believe that they were covered under the policy if they answered the questions to the best of their knowledge and the insurer subsequently issued the policy. To permit an insurer to rescind a policy containing

"knowledge and belief"

language due to an unknowing misstatement not only contravenes the

terms of the contract itself, but is unfair as well. Insurance applicants faced with a policy that unambiguously stated that it could be voided for unknowing misstatements might have rejected those terms and sought another policy, or they might have undergone a full physical examination to ensure that their beliefs as to their health conformed to their representations. Conversely, had Provident really thought it essential to know the actual physical condition of its applicants, it could have mandated a full physical examination and investigation as a condition of issuing a policy.

The courts have established safeguards in order to ensure that the applicant cannot claim ignorance of otherwise obvious medical conditions.

In SKINNER, supra, the court held that what the applicant in fact believed to be true is the determining factor in judging the truth or falsity of his answer, but only so far as that belief is not clearly contradicted by factual knowledge on which it was based. In such event, the court may properly find the statement false as a matter of law, however sincerely it may be believed.

CONCLUSION

It is respectfully submitted that the Petitioner in this case belongs to a class of people whose plight has become all too familiar over the years. The clout which is wielded by the insurance industry in the halls of the various state legislatures has risen to legendary status.

Petitioner has demonstrated in his brief that the statutory provisions regulating the insurance industry, instead of clarifying the issues, have muddied the waters and left the issues to be resolved by the court system. However, instead of achieving uniformity in the areas of material misrepresentation and

incontestability provisions, the decisions of the courts have led to even greater confusion.

It is difficult to imagine a topic of more importance to the average American than access to affordable and reliable insurance for one's family. If insurance companies such as Provident are allowed to continue to enjoy the upper hand in determining the terms, and in some cases the very existence, of an insurance contract, the american public will find itself at the mercy of an ever-growing enterprise which can leave it virtually helpless at the time of greatest need.

The need for uniformity in an industry whose very existence depends upon its credibility among the policy

holders and the unfair advantage it enjoys over the average insured is so obvious that it need not be stated.

Provident has placed itself in the most unenviable position of being one of the most litigious companies in the insurance business, having involved itself in litigation far out of proportion to its size. This fact lends further credibility to the assertions previously made.

It is well documented that Provident has used its leverage within the industry to invade the domain of the federal government where its high-handed tactics have resulted in accusations of Medicare fraud whereby millions of dollars of taxpayer money has been squandered. It can safely be said that such abuses will continue

if left unchecked. (Please see Exhibit "G" - front page Sunday article in the MIAMI HERALD daily newspaper.)

The Petitioner prays that this Honorable Court will seize this opportunity to tighten the reigns on an industry which has grown to unwieldy proportions and to achieve the uniformity of judicial decision-making which is so desperately needed.